		FOR OHF USE					

LL I

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0003020

Facility Name: MENARD CONVALESCENT CENTER

Address: 120 W. ANTLE (Number) PETERSBURG (City) 62675 (Zip Code)

County: MENARD

Telephone Number: 217-632-2249 **Fax #** 217-632-2314

IDPA ID Number: 37-0856151001

Date of Initial License for Current Owners: 12/1/66

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: JERRY W. JENNINGS **Telephone Number:** 217 787-8530

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/01/99 to 11/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed) _____ (Date)
	(Type or Print Name) JERRY W. JENNINGS
	(Title) CONTROLLER
Paid Preparer	(Signed) _____ (Date)
	(Print Name and Title)
	(Firm Name & Address)
	(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Print Preview

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period		2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	59	59	Skilled (SNF)	59	21,594	1
2			Skilled Pediatric (SNF/PED)			2
3	27	27	Intermediate (ICF)	27	9,882	3
4			Intermediate/DD			4
5			Sheltered Care (SC)			5
6			ICF/DD 16 or Less			6
7		86	TOTALS	86	31,476	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,134	2,134	8
9	SNF/PED					9
10	ICF	11,247	5,073		16,320	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	11,247	5,073	2,134	18,454	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 58.63%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started / / 66

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 19 and days of care provided _____

Medicare Intermediary ADMINASTAR FEDERAL OF KENTUCKY

IV. ACCOUNTING BASIS

ACCRUAL		MODIFIED CASH*		CASH*	
	X				

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 11/30/00 Fiscal Year: 11/30/00

* All facilities other than governmental must report on the accrual basis.

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	74,679	9,532	3,960	88,171		88,171	0	88,171			1
2	Food Purchase		59,265		59,265		59,265	(2,195)	57,070			2
3	Housekeeping	22,950	6,636		29,586		29,586	0	29,586			3
4	Laundry	14,111	6,186		20,297		20,297	0	20,297			4
5	Heat and Other Utilities			46,437	46,437		46,437	0	46,437			5
6	Maintenance	21,714	16,399	26,465	64,578		64,578	391	64,969			6
7	Other (specify):* Utility Workers	25,539			25,539		25,539	0	25,539			7
8	TOTAL General Services	158,993	98,018	76,862	333,873		333,873	(1,804)	332,069			8
	B. Health Care and Programs											
9	Medical Director	12,066		6,000	18,066		18,066	0	18,066			9
10	Nursing and Medical Records	421,941	78,276	57,860	558,077	(56,725)	501,352	58	501,410			10
10a	Therapy	16,735	487	76,993	94,215	(76,993)	17,222	0	17,222			10a
11	Activities	21,658	1,150		22,808		22,808	0	22,808			11
12	Social Services			2,555	2,555		2,555	0	2,555			12
13	Nurse Aide Training	2,155		1,710	3,865		3,865	0	3,865			13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	474,555	79,913	145,118	699,586	(133,718)	565,868	58	565,926			16
	C. General Administration											
17	Administrative	48,094		5,469	53,563	761	54,324	22,247	76,571			17
18	Directors Fees							0				18
19	Professional Services			102,229	102,229		102,229	(95,870)	6,359			19
20	Dues, Fees, Subscriptions & Promotions			6,134	6,134		6,134	(1,716)	4,418			20
21	Clerical & General Office Expenses	20,138	4,943	4,450	29,531		29,531	10,093	39,624			21
22	Employee Benefits & Payroll Taxes			100,157	100,157		100,157	6,330	106,487			22
23	Inservice Training & Education			1,042	1,042		1,042	72	1,114			23
24	Travel and Seminar			1,331	1,331	(1,039)	292	1,029	1,321			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			58,181	58,181		58,181	200	58,381			26
27	Other (specify):*			7,208	7,208		7,208	(7,208)				27
28	TOTAL General Administration	68,232	4,943	286,201	359,376	(278)	359,098	(64,823)	294,275			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	701,780	182,874	508,181	1,392,835	(133,996)	1,258,839	(66,569)	1,192,270			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			21,176	21,176		21,176	6,790	27,966			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest							0				32
33	Real Estate Taxes			14,221	14,221		14,221	0	14,221			33
34	Rent-Facility & Grounds							2,536	2,536			34
35	Rent-Equipment & Vehicles							0				35
36	Other (specify):*							0				36
37	**TOTAL Ownership**			35,397	35,397		35,397	9,326	44,723			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers					133,996	133,996	0	133,996			39
40	Barber and Beauty Shops							0				40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			47,214	47,214		47,214	0	47,214			42
43	Other (specify):*							0				43
44	**TOTAL Special Cost Centers**			47,214	47,214	133,996	181,210		181,210			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	701,780	182,874	590,792	1,475,446	0	1,475,446	(57,243)	1,418,203			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	5,648	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(1,158)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,814)	27		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,282)	27		24
25	Fund Raising, Advertising and Promotional	(1,495)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(112)	27		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(287)	20		28
29	Other-Attach Schedule VENDING	(2,195)	2		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (6,695)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(45,405)	VAR	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (45,405)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (52,100)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39	THERAPY	X		76,993	10A	39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		195	10	42
43	Prescription Drugs	X		49,421	10	43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule OXYGEN	X		6,736	10	45
46	Other-Attach Schedule Med Supplies	X		651	10	46
47	**TOTAL (C): (sum of lines 38-46)**			$ 133,996		47

Print Preview

Detail lines 29 and 35 of Page 9 starting in B44. DO NOT DRAG AND DROP CELLS.

The amounts in column F will transfer to the Adj. Summary column automatically.

The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page-9A**

Facility Name: MENARD CORRECTIONAL CENTER

CCN: 140218

Report Period Beginning: 12/01/99

Ending: 12/31/99

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference
The information listed in B13 thru G43 is from Page 5.			
1	**Day Care**	0	0
2	**Other Care for Outpatients**	0	0
3	**Governmental Sponsored Special Programs**	0	0
4	**Non-Patient Meals**	0	0
5	**Telephone, TV & Radio in Resident Rooms**	0	0
6	**Rented Facility Space**	0	0
7	**Sale of Supplies to Non-Patients**	0	0
8	**Laundry for Non-Patients**	0	0
9	**Non-Straight-line Depreciation**	5,448	30
10	**Interest and Other Investment Income**	0	0
11	**Discounts, Allowances, Rebates & Refunds**	(1,158)	21
12	**Non-Working Officer's or Owner's Salary**	0	0
13	**Sales Tax**	(1,816)	27
14	**Non-Care Related Interest**	0	0
15	**Non-Care Related Owner's Transactions**	0	0
16	**Personal Expenses (Including Transportation)**	0	0
17	**Non-Care Related Fees**	0	0
18	**Fines and Penalties**	0	0
19	**Entertainment**	0	0
20	**Contributions**	0	0
21	**Owner or Key Man Insurance**	0	0
22	**Special Legal Fees & Legal Retainers**	0	0
23	**Life Insurance Insurance for Individuals**	0	0
24	**Bad Debts**	(5,282)	27
25	**Fund Raising, Advertising and Promotional**	(1,495)	20
26	**Income & IL Personal Property Replacement Taxes**	(112)	27
27	**Nurse Aide Training for Non-Employees**	0	0
28	**Yellow Page Advertising**	(267)	20
29	**Non-Paid Workers**	0	0
30	**Donated Goods**	0	0
31	**Amortization Expense**	0	0
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Sch V	Adj. Summary
Line 1	0
Line 2	0
Line 3	0
Line 4	0
Line 5	0
Line 6	0
Line 7	0
Line 8	0
Line 9	0
Line 10	0
Line 10a	0
Line 11	0
Line 12	0
Line 13	0
Line 14	0
Line 15	0
Line 16	0
Line 17	0
Line 18	0
Line 19	0
Line 20	(1,786)
Line 21	(1,158)
Line 22	0
Line 23	0
Line 24	0
Line 25	0
Line 26	0
Line 27	(7,402)
Line 28	(10,144)
Line 29	(10,144)
Line 30	5,448
Line 31	0
Line 32	0
Line 33	0
Line 34	0
Line 35	0
Line 36	0
Line 37	0
Line 38	0
Line 39	0
Line 40	0
Line 41	0
Line 42	0
Line 43	0
Line 44	0
Line 45	(4,696)

To Print the Other Adjustments you have entered.

1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure to include highlighted rows 0 thru G.**
2. **Push the Print Other Adjustments button.**

Print Other Adjustments

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary A

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	462	0	0	0	0	0	0	0	0	0	462	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(95,953)	0	0	0	0	0	0	0	0	0	(95,953)	19
20	Fees, Subscriptions & Promotions	(1,782)	0	0	0	0	0	0	0	0	0	0	(1,782)	20
21	Clerical & General Office Expenses	(1,158)	0	0	0	0	0	0	0	0	0	0	(1,158)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	(462)	0	0	0	0	0	0	0	0	0	(462)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(7,208)	0	0	0	0	0	0	0	0	0	0	(7,208)	27
28	**TOTAL General Administration**	(10,148)	(95,953)	0	0	0	0	0	0	0	0	0	(106,101)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(10,148)	(95,953)	0	0	0	0	0	0	0	0	0	(106,101)	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary B

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	5,648	0	0	0	0	0	0	0	0	0	0	5,648	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	5,648	0	0	0	0	0	0	0	0	0	0	5,648	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(4,500)	(95,953)	0	0	0	0	0	0	0	0	0	(100,453)	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT
FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0903820 Report Period Beginning: 12/01/99 Ending: 11/30/00

VII. RELATED PARTIES

Show Pgs 6A thru 6D | Show Pgs 6E thru 6I | Hide Pgs 6A thru 6I

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SAM KLEIN	25%	D'ADRIAN CONVALESCENT CENTER, INC	GODFREY	Nursing Home Mngt	SPRINGFIELD	MANAGEMENT
H. RAYMOND KLEIN	25%	HILLTOP NURSING HOME, INC.	CHARLESTON			
HOBART SCHAFER	25%	JACKSONVILLE CONV. CENTER, INC.	JACKSONVILLE			
BARRY FREE	25%	MEADOW MANOR, INC.	TAYLORVILLE			
		SUNRISE MANOR OF VIRDEN, INC.	VIRDEN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger		4	5 Cost to Related Organization	6	7	8 Difference:		Sum_6
Schedule V	Line	Item		Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	18 MANAGEMENT FEE	$	102,631	NURSING HOME MANAGERS, INC.	99.00%	$	$ (102,631)	1	-102031
2	V	VAR SEE ATTACHED SCHEDULES			NURSING HOME MANAGERS, INC.		45,405	45,405	2	45405
3	V	18 OCCUPANCY			NURSING HOME MANAGERS, INC. - DIRECT ALLOCATION		6.078	6,078	3	6078
4	V	24 TRAVEL		462	TO TRANSFER 25% OF HOME OFFICE TRAVEL			(462)	4	-462
5	V	27 ADMINISTRATIVE			TO ADMINISTRATIVE PER DISK REVIEW		462	462	5	462
6	V								6	
7	V								7	
8	V								8	
9	V								9	
10	V								10	
11	V								11	
12	V								12	
13	V								13	
14	Total		$	102,493			$ 51,945	$ (50,548)	14	

* Total must agree with the amount recorded on line 34 of Schedule VI.

Print Preview

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SAM KLEIN	PRESIDENT	MANAGEMENT	25.00					$	17-7	1
2	H. RAYMOND KLEIN	OWNER	MANAGEMENT	25.00						17-7	2
3	ROBERT SCHAFER	MED. DIRECTOR	MED. DIRECTOR	25.00		6	12.00		12,066	9-1	3
4											4
5											5
6			Sam Klein and H. Raymond Klein were paid by Nursing Home Managers, Inc.,								6
7			a related organization. Total compensation of $10010 for each Sam Klein and								7
8			H. Raymond Klein was allocated among the six related nursing homes, based								8
9			upon 10 hours per week for Sam Klein and 10 hours per week for H. Raymond Klein.								9
10											10
11											11
12											12
13								TOTAL	$ 12,066		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Print Preview

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8D | Show Pgs 8E thru 8I | Hide Pgs 8A thru 8I

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NURSING HOME MANAGERS, INC.
Street Address: 2653 W. LAWRENCE AVENUE, SUITE B
City / State / Zip Code: SPRINGFIELD, IL 62704
Phone Number: (217) 787-8530
Fax Number: (217) 787-9840

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3			SEE ATTACHED SCHEDULES							3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Print Preview

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 0	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Print Preview

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	12,364	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	13,871	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,507	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	12,714	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ ____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	14,221	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	14,147	8
1996	13,420	9
1997	13,496	10
1998	13,488	11
1999	13,870	12

LINE 4 ACCRUAL 11/12 x 13870 = 12714

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Print Preview

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,211 B. General Construction Type: Exterior MASONRY Frame STEEL Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	93,436	1993-1994	$ 9,919	1
2					2
3	TOTALS	93,436		$ 9,919	3

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12B | Show Pgs 12C and 12D | Hide Pgs 12A thru 12D

STATE OF ILLINOIS

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	54		1966	1966-1969	$ 172,985	$ 1,203	30	$	$ (1,203)	$ 172,985	4
5	32		1974	1974	148,705	1,900	30	4,957	3,057	149,362	5
6											6
7											7
8											8
	Improvement Type**										
9	LANDSCAPING			1966	5,308					5,308	9
10	FIRE DOOR			1979	1,433					1,433	10
11	FIRE DOOR			1981	8,340					8,340	11
12	BATHROOM			1984	7,335	293	30	245	(48)	4,042	12
13	AIR CONDITIONER			1984	1,100	44	8		(44)	1,100	13
14	ELECTRICAL & PLUMBING			1985	11,117	618	15	741	123	11,485	14
15	PLUMBING			1986	4,921	256	15	328	72	4,757	15
16	SMOKE DETECTORS			1986	10,445	543	25	418	(125)	6,061	16
17	AIR CONDITIONER			1986	2,235	116	10		(116)	2,235	17
18	PLUMBING			1986	1,145	60	20	57	(3)	827	18
19	ROOF			1987	6,362	264	20	318	54	4,293	19
20	WATER HEATER & WINDOWS			1988	6,530	207	15	435	228	5,715	20
21	NURSE CALL			1988	1,674	53	10	167	114	1,670	21
22	ROOF			1989	30,672	974	20	1,534	560	17,641	22
23	WATER HEATER & PARKING LOT			1989	11,502	365	15	767	402	8,820	23
24	FURNACE & FLOORING			1990	19,165	608	15	1,278	670	13,419	24
25	AIR CONDITIONER			1991	2,633	84	15	176	92	1,672	25
26	PLUMBING FAUCETS			1992	8,909	283	15	594	311	5,049	26
27	DOOR ALARM			1992	1,572	50	20	79	29	789	27
28	WATER HEATER & GARAGE DOOR			1993	4,348	138	15	290	152	2,175	28
29	WATER HEATER & PLUMBING			1994	5,074	130	15	338	208	2,197	29
30	LANDSCAPING			1994	3,900	230	15	260	30	1,625	30
31	AIR CONDITIONER & ROOF			1995	7,049	181	15	470	289	2,585	31
32	REMODEL BATHROOMS-TILE, CEILING,& FIXTURES			1996	19,751	507	15	1,317	810	5,926	32
33	AIR CONDITIONER			1997	1,710	44	15	114	70	399	33
34	FIRE DAMPERS			1998	4,076	105	15	272	167	680	34
35	FURNACE			1998	2,200	56	15	147	91	367	35
36	TOTAL (lines 4 thru 35)				$ 512,196	$ 9,312		$ 15,302	$ 5,990	$ 442,957	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12A

STATE OF ILLINOIS

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	GREASE TRAP			1999	2,824	72	15	188	116	282	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 2,824	$ 72		$ 188	$ 116	$ 282	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12B

STATE OF ILLINOIS

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 116,839	$ 10,291	$ 10,959	$ 668	VARIOUS	$ 58,215	37
38	Current Year Purchases	10,503	1,501	375	(1,126)	VARIOUS	375	38
39	Fully Depreciated Assets	127,768					127,768	39
40	Assets No Longer in Service	(73,230)					(73,230)	40
41	TOTALS	$ 181,880	$ 11,792	$ 11,334	$ (458)		$ 113,128	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 706,819	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 21,176	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 26,824	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 5,648	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 556,367	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [X]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		30		30
3	Classroom Wages (a)	66	1,676		1,742
4	Clinical Wages (b)		412		412
5	In-House Trainer Wages (c)				
6	Transportation		538		538
7	Contractual Payments	45	1,097		1,142
8	Nurse Aide Competency Tests				
9	TOTALS	$ 111	$ 3,753	$	$ 3,864
10	SUM OF line 9, col. 1 and 2 (e)	$ 3,864			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	3

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A-5	hrs	$	655	$ 27,699	$	655	$ 27,699	1
2	Licensed Speech and Language Development Therapist	10A-5	hrs		187	6,387		187	6,387	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A-5	hrs		951	42,907		951	42,907	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	10-5	# of prescrpts				49,421		49,421	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	OXYGEN Other (specify): Med Supp & Labs	10-5 10-5					6,736 846		6,736 846	13
14	TOTAL			$	1,792	$ 76,993	$ 57,003	1,792	$ 133,996	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Print Preview

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 11/30/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 107,080	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	252,215		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,205		6
7	Other Prepaid Expenses	135		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 396,635	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,919		13
14	Buildings, at Historical Cost	515,019		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	250,656		16
17	Accumulated Depreciation (book methods)	(618,458)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 157,136	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 553,771	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 87,560	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	26,229		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,637		31
32	Accrued Real Estate Taxes(Sch.IX-B)	12,715		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	112		35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 129,253	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 129,253	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 424,518	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 553,771	$	48

***(See instructions.)**

Print Preview

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 398,448	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 398,448	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	26,070	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 26,070	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 424,518	24 *

*** This must agree with page 17, line 47.**

Print Preview

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,567,711	1
2	Discounts and Allowances for all Levels	(110,124)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,457,587	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	29,073	6
7	Oxygen	3,805	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 32,878	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	761	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	975	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,736	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	4,048	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 4,048	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending 2195 Adm Fee 1005 W/A 40	3,240	28
28a	Flu Shots 1914 Expense Reimbursement 113	2,027	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,267	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,501,516	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 333,873	31
32	Health Care	699,586	32
33	General Administration	359,376	33
	B. Capital Expense		
34	Ownership	35,397	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	47,214	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,475,446	40
41	**Income before Income Taxes (line 30 minus line 40)****	26,070	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 26,070	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Print Preview

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,120	2,120	$ 38,803	$ 18.30	1
2	Assistant Director of Nursing					2
3	Registered Nurses	3,079	3,203	53,333	16.65	3
4	Licensed Practical Nurses	11,372	11,948	132,330	11.08	4
5	Nurse Aides & Orderlies	28,073	28,987	197,475	6.81	5
6	Nurse Aide Trainees	419	419	2,155	5.15	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,937	2,058	16,735	8.13	8
9	Activity Director	1,786	1,843	12,019	6.52	9
10	Activity Assistants	1,567	1,621	9,639	5.95	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,938	2,070	19,080	9.22	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,033	9,252	55,599	6.01	15
16	Dishwashers					16
17	Maintenance Workers	3,478	3,573	21,714	6.08	17
18	Housekeepers	4,262	4,330	22,950	5.30	18
19	Laundry	2,372	2,458	14,111	5.74	19
20	Administrator	2,000	2,080	48,094	23.12	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,001	2,098	20,138	9.60	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director	300	300	12,066	40.22	27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Utility Workers	4,847	4,884	25,539	5.23	33
34	TOTAL (lines 1 - 33)	80,584	83,242	$ 701,780 *	$ 8.43	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

Print Preview

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B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	144	$ 3,960	1-3	35
36	Medical Director	120	6,000	9-3	36
37	Medical Records Consultant	16	515	10-3	37
38	Nurse Consultant	282	8,444	10-3	38
39	Pharmacist Consultant	48	774	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	45	2,555	12-3	45
46	Other(specify)				46
47	Administrative Consultant	241	5,469	17-3	47
48					48
49	TOTAL (lines 35 - 48)	896	$ 27,717		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	857	21,526	10-3	51
52	Nurse Aides	1,447	26,406	10-3	52
53	TOTAL (lines 50 - 52)	2,304	$ 47,932		53

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
STEVEN TERRITO	ADMINISTRATOR	0.00%	$ 48,094
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 48,094

B. Administrative - Other

Description	Amount
ADMINISTRATIVE CONSULTANT	$ 5,469
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 5,469

C. Professional Services

Vendor/Payee	Type	Amount
NURSING HOME MANAGERS	MANAGEMENT FEE	$ 102,031
CSC	CORP. REPRESENTATION	198
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 102,229

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 24,028
Unemployment Compensation Insurance	6,059
FICA Taxes	51,995
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
CAFETERIA PLAN	15,591
EMPLOYEE LIFE INSURANCE	1,619
HOLIDAY PARTY	100
GIFT CERTIFICATES	765
NHM ALLOCATION	6,330
TOTAL (agree to Schedule V, line 22, col.8)	$ 106,487

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
HOLIDAY PARTY	22	$ 100
GIFT CERTIFICATES	22	765
TOTAL		$ 865

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,557
Health Care Worker Background Check	540
(Indicate # of checks performed 45)	
YELLOW PAGES	287
PUBLIC RELATIONS	1,495
HCFA LAB FEE	150
FRANCHISE TAX	105
NHM ALLOCATION	66
Less: Public Relations Expense	(1,495)
Non-allowable advertising	( )
Yellow page advertising	(287)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,418

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
ADMINISTRATOR	282
MISCELLANEOUS	10
NHM ALLOCATION	1,029
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,321

**See instructions.

Print Preview

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINTING	6/90	$ 1,471	3 YRS	$	$	$	$	$	$	$	$	$
2	PAINTING	7/91	1,450	3 YRS									
3	PAINTING	7/94	2,726	3 YRS	454								
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 5,647		$ 454	$	$	$	$	$	$	$	$

Print Preview

Facility Name & ID Number MENARD CONVALESCENT CENTER # 0003020 Report Period Beginning: 12/01/99 Ending: 11/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 15 YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 492 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 47,214
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? YES If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? N/A Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Print Preview

SCHEDULE V

PAGE 3 LINE 27 COLUMN 3
OTHER COSTS

RT TAX	$	112
SALES TAX		1814
BAD DEBT		5282
	$	7208

SCHEDULE XI

PAGE 13 SECTION E
RECONCILIATION OF INCOME

LINE 49	$	26824
NURSING HOME MANAGERS ALLOCATION		1142
SCHEDULE V LINE 30 COLUMN 8	$	27966

COLUMN 5 RECLASSIFICATION

RECLASS FROM:			LINE #
LABS	$	-195	10
MEDICARE DRUGS		-49421	10
MEDICARE SUPPLIES		-651	10
OXYGEN		-6736	10
PHYSICAL THERAPY		-42907	10A
SPEECH THERAPY		-6387	10A
OCCUPATIONAL THERAPY		-27699	10A
RECLASS TO: ANCILLARY	$	133996	39

RECLASS TO:			
NURSE CONSULTANT TRAVEL	$	278	10
ADMINISTRATIVE CONSULTANT TRAVEL		761	17
RECLASS FROM: TRAVEL	$	-1039	24

SCHEDULE XVII PAGE 19 LINE 41
RECONCILIATION OF INCOME

NET INCOME	$	26070
* ACCRUED MANAGEMENT FEE 11/99		-19166
* ACCRUED MANAGEMENT FEE 11/00		8769
INTEREST INCOME PASSED DIRECTLY TO STOCKHOLDERS		-4009
	$	11664

* RELATED PARTY ACCOUNTS PAYABLE NOT ALLOWED FOR TAX PURPOSES INCLUDED HERE FOR CONSISTENCY WITH PRIOR COST REPORTS AND TO CONFORM TO ACCRUAL ACCOUNTING METHODS

SCHEDULE XIII
PAGE 15

TRAINED AT: SUNRISE MANOR OF VIRDEN, INC
333 S. WRIGHTSMAN
VIRDEN, IL 62690

COST PER AIDE TRAINED 3 @ $549

PAGE 23 QUESTION 12

SALARY COST ALLOCATED TO DEPARTMENT WORKED BASED UPON TIME CARDS

SCHEDULE VII - PAGE 6, LINE 2

CENTRAL OFFICE COST ALLOCATION
MENARD
1999

	DEC 99	JAN 00	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	1999 TOTAL
SALARIES-ADMIN	$1,791	$1,668	$1,713	$1,704	$1,696	$1,659	$1,694	$1,657	$1,291	$1,415	$1,507	$1,486	$19,282
SALARIES-CLERIC	886	856	879	874	870	851	869	850	681	747	795	784	9,941
SALARIES-ACTIV	0	0	0	0	0	0	0	0	0	0	0	0	0
SALARIES-NURSE	58	0	0	0	0	0	0	0	0	0	0	0	58
ACCOUNTING	17	5	6	6	6	5	6	5	6	7	7	7	83
WORK COMP INS	3	9	9	9	9	9	9	9	16	18	19	19	137
SUPPLIES	40	81	83	83	83	81	82	81	25	27	29	29	724
TELEPHONE	34	39	40	39	39	38	39	38	63	69	74	73	586
EMPL BENEFITS	273	276	283	282	280	274	280	274	341	373	398	392	3,725
PAYROLL TAXES	207	205	211	210	209	204	208	204	184	201	214	211	2,468
TRAVEL	21	118	121	120	120	117	120	117	144	158	169	166	1,491
IN SERVICE	3	8	8	8	8	8	8	8	3	3	3	3	72
MEDICAL CONSULT	0	0	0	0	0	0	0	0	0	0	0	0	0
MACHINE RENTAL	2	13	13	13	13	13	13	13	(0)	(0)	(0)	(0)	92
OWNERS COMP	208	196	201	200	199	195	199	194	207	227	241	238	2,503
INS-PROP,LIAB,WC	14	14	15	15	14	14	14	14	19	21	23	22	200
DEPRECIATION	87	91	93	93	92	90	92	90	93	102	109	107	1,142
RENT	201	201	207	205	204	200	204	200	207	227	242	238	2,536
MAINTENANCE	46	16	17	17	17	16	17	16	31	34	37	36	299
FEES & PUBLICAT	18	3	3	3	3	3	3	3	3	3	4	4	55
ADVERTISING		2	2	2	2	2	2	2	0	0	0	0	11
		0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	$3,911	$3,801	$3,903	$3,882	$3,864	$3,780	$3,858	$3,776	$3,314	$3,633	$3,869	$3,814	45,405
FIXED ASSETS													45,404
EQUIP - PRIOR	6,638	5,446	5,592	5,562	5,536	5,416	5,528	5,410	5,602	6,141	6,540	6,448	5,822
EQUIP - CURR	850	1,102	1,373	2,561	2,549	2,494	2,545	2,491	2,579	2,828	3,011	2,968	2,279
EQUIP - FULLY DEP	688	666	684	680	677	662	676	662	685	751	800	788	702
BLDG - PRIOR	825	798	819	815	811	793	810	792	821	900	958	944	840
BLDG - CURR	0	0	0	0	0	0	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
DECEMBER 1999

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	19.08%	14.49%	16.87%	20.33%	12.26%	16.97%	100.00%
SALARIES-ADMIN	$2,787	$2,117	$2,465	$2,969	$1,791	$2,479	$14,609
SALARIES-CLERIC	1,379	1,047	1,220	1,469	886	1,226	7,228
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	91	69	80	97	58	81	476
ACCOUNTING	26	20	23	28	17	23	138
WORK COMP INS	5	4	4	5	3	4	25
SUPPLIES	62	47	55	66	40	55	324
TELEPHONE	53	40	47	57	34	47	279
EMPL BENEFITS	425	323	376	453	273	378	2,229
PAYROLL TAXES	322	245	285	343	207	287	1,689
TRAVEL	33	25	29	35	21	29	171
IN SERVICE	5	4	5	5	3	5	27
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	3	3	3	4	2	3	18
OWNERS COMP	323	245	286	344	208	287	1,694
INS-PROP,LIAB,WC	22	17	20	24	14	20	118
DEPRECIATION	136	103	120	145	87	121	711
RENT	313	238	277	334	201	279	1,642
MAINTENANCE	72	54	63	76	46	64	375
FEES & PUBLIC	28	21	25	30	18	25	146
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$6,086	$4,622	$5,383	$6,484	$3,911	$5,413	$31,897
FIXED ASSETS							
EQUIP - PRIOR	10,329	7,844	9,135	11,004	6,638	9,187	54,137
EQUIP - CURR	1,323	1,005	1,170	1,410	850	1,177	6,936
EQUIP - FULLY DEP	1,071	813	947	1,141	688	953	5,614
BLDG - PRIOR	1,283	974	1,135	1,367	825	1,141	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JANUARY 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	19.63%	14.63%	17.50%	20.31%	11.86%	16.07%	100.00%
SALARIES-ADMIN	$2,762	$2,058	$2,461	$2,856	$1,668	$2,261	$14,066
SALARIES-CLERIC	1,417	1,056	1,262	1,465	856	1,160	$7,216
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	0	0	0	0	0	$0
ACCOUNTING	9	7	8	9	5	7	$46
WORK COMP INS	15	11	13	15	9	12	$75
SUPPLIES	134	100	120	139	81	110	$685
TELEPHONE	64	48	57	66	39	52	$326
EMPL BENEFITS	456	340	407	472	276	374	$2,324
PAYROLL TAXES	340	253	303	351	205	278	$1,730
TRAVEL	195	145	174	202	118	160	$993
IN SERVICE	13	10	12	14	8	11	$68
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	21	16	19	22	13	17	$108
OWNERS COMP	324	241	289	335	196	265	$1,650
INS-PROP,LIAB,WC	24	18	21	24	14	19	$120
DEPRECIATION	150	112	134	156	91	123	$766
RENT	333	248	297	344	201	273	$1,696
MAINTENANCE	27	20	24	28	16	22	$137
FEES & PUBLIC	5	4	4	5	3	4	$25
ADVERTISING	3	2	2	3	2	2	$13
	0	0	0	0	0	0	$0
TOTAL	$6,291	$4,688	$5,606	$6,507	$3,801	$5,150	$32,044
FIXED ASSETS							
EQUIP - PRIOR	9,014	6,717	8,033	9,323	5,446	7,379	45,912
EQUIP - CURR	1,824	1,359	1,625	1,886	1,102	1,493	9,290
EQUIP - FULLY DEP	1,102	821	982	1,140	666	902	5,614
BLDG - PRIOR	1,320	984	1,177	1,366	798	1,081	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
FEBRUARY 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.62%	14.24%	18.31%	19.79%	12.18%	16.86%	100.00%
SALARIES-ADMIN	$2,620	$2,003	$2,576	$2,784	$1,713	$2,371	$14,066
SALARIES-CLERIC	1,344	1,028	1,321	1,428	879	1,216	$7,216
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	0	0	0	0	0	$0
ACCOUNTING	9	7	8	9	6	8	$46
WORK COMP INS	14	11	14	15	9	13	$75
SUPPLIES	128	98	125	136	83	115	$685
TELEPHONE	61	46	60	65	40	55	$326
EMPL BENEFITS	433	331	426	460	283	392	$2,324
PAYROLL TAXES	322	246	317	342	211	292	$1,730
TRAVEL	185	141	182	196	121	167	$993
IN SERVICE	13	10	12	13	8	11	$68
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	20	15	20	21	13	18	$108
OWNERS COMP	307	235	302	327	201	278	$1,650
INS-PROP,LIAB,WC	22	17	22	24	15	20	$120
DEPRECIATION	143	109	140	152	93	129	$766
RENT	316	241	311	336	207	286	$1,696
MAINTENANCE	26	20	25	27	17	23	$137
FEES & PUBLIC	5	4	5	5	3	4	$25
ADVERTISING	3	2	2	3	2	2	$13
	0	0	0	0	0	0	$0
TOTAL	$5,968	$4,563	$5,867	$6,341	$3,903	$5,402	$32,044
FIXED ASSETS							
EQUIP - PRIOR	8,550	6,538	8,407	9,085	5,592	7,740	45,912
EQUIP - CURR	2,100	1,606	2,065	2,231	1,373	1,901	11,276
EQUIP - FULLY DEP	1,046	799	1,028	1,111	684	946	5,614
BLDG - PRIOR	1,252	958	1,231	1,331	819	1,134	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MARCH 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.40%	13.69%	18.79%	19.36%	12.11%	17.64%	100.00%
SALARIES-ADMIN	$2,588	$1,926	$2,643	$2,724	$1,704	$2,482	$14,066
SALARIES-CLERIC	1,328	988	1,356	1,397	874	1,273	$7,216
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	0	0	0	0	0	$0
ACCOUNTING	8	6	9	9	6	8	$46
WORK COMP INS	14	10	14	15	9	13	$75
SUPPLIES	126	94	129	133	83	121	$685
TELEPHONE	60	45	61	63	39	58	$326
EMPL BENEFITS	428	318	437	450	282	410	$2,324
PAYROLL TAXES	318	237	325	335	210	305	$1,730
TRAVEL	183	136	187	192	120	175	$993
IN SERVICE	12	9	13	13	8	12	$68
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	20	15	20	21	13	19	$108
OWNERS COMP	304	226	310	320	200	291	$1,650
INS-PROP,LIAB,WC	22	16	22	23	15	21	$120
DEPRECIATION	141	105	144	148	93	135	$766
RENT	312	232	319	328	205	299	$1,696
MAINTENANCE	25	19	26	27	17	24	$137
FEES & PUBLIC	5	3	5	5	3	4	$25
ADVERTISING	2	2	3	3	2	2	$13
	0	0	0	0	0	0	$0
TOTAL	$5,896	$4,386	$6,022	$6,205	$3,882	$5,653	$32,044
FIXED ASSETS							
EQUIP - PRIOR	8,447	6,285	8,628	8,890	5,562	8,100	45,912
EQUIP - CURR	3,889	2,894	3,972	4,093	2,561	3,729	21,138
EQUIP - FULLY DEP	1,033	769	1,055	1,087	680	990	5,614
BLDG - PRIOR	1,237	921	1,264	1,302	815	1,186	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
APRIL 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.32%	13.47%	19.24%	19.54%	12.06%	17.37%	100.00%
SALARIES-ADMIN	$2,577	$1,895	$2,706	$2,748	$1,696	$2,443	$14,066
SALARIES-CLERIC	1,322	972	1,388	1,410	870	1,253	$7,216
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	0	0	0	0	0	$0
ACCOUNTING	8	6	9	9	6	8	$46
WORK COMP INS	14	10	14	15	9	13	$75
SUPPLIES	125	92	132	134	83	119	$685
TELEPHONE	60	44	63	64	39	57	$326
EMPL BENEFITS	426	313	447	454	280	404	$2,324
PAYROLL TAXES	317	233	333	338	209	300	$1,730
TRAVEL	182	134	191	194	120	172	$993
IN SERVICE	12	9	13	13	8	12	$68
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	20	15	21	21	13	19	$108
OWNERS COMP	302	222	317	322	199	287	$1,650
INS-PROP,LIAB,WC	22	16	23	23	14	21	$120
DEPRECIATION	140	103	147	150	92	133	$766
RENT	311	228	326	331	204	295	$1,696
MAINTENANCE	25	19	26	27	17	24	$137
FEES & PUBLIC	5	3	5	5	3	4	$25
ADVERTISING	2	2	3	3	2	2	$13
	0	0	0	0	0	0	$0
TOTAL	$5,871	$4,316	$6,165	$6,261	$3,864	$5,566	$32,044
FIXED ASSETS							
EQUIP - PRIOR	8,412	6,184	8,834	8,971	5,536	7,975	45,912
EQUIP - CURR	3,873	2,847	4,067	4,130	2,549	3,672	21,138
EQUIP - FULLY DEP	1,029	756	1,080	1,097	677	975	5,614
BLDG - PRIOR	1,232	906	1,294	1,314	811	1,168	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
MAY 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.75%	13.78%	18.35%	20.45%	11.80%	16.89%	100.00%
SALARIES-ADMIN	$2,637	$1,938	$2,581	$2,876	$1,659	$2,376	$14,066
SALARIES-CLERIC	1,353	994	1,324	1,475	851	1,219	$7,216
SALARIES-ACTIV	0	0	0	0	0	0	$0
SALARIES-NURSE	0	0	0	0	0	0	$0
ACCOUNTING	9	6	8	9	5	8	$46
WORK COMP INS	14	10	14	15	9	13	$75
SUPPLIES	128	94	126	140	81	116	$685
TELEPHONE	61	45	60	67	38	55	$326
EMPL BENEFITS	436	320	426	475	274	393	$2,324
PAYROLL TAXES	324	238	317	354	204	292	$1,730
TRAVEL	186	137	182	203	117	168	$993
IN SERVICE	13	9	12	14	8	11	$68
MEDICAL CONSULT	0	0	0	0	0	0	$0
MACHINE RENTAL	20	15	20	22	13	18	$108
OWNERS COMP	309	227	303	337	195	279	$1,650
INS-PROP,LIAB,WC	22	16	22	24	14	20	$120
DEPRECIATION	144	106	141	157	90	129	$766
RENT	318	234	311	347	200	286	$1,696
MAINTENANCE	26	19	25	28	16	23	$137
FEES & PUBLIC	5	3	5	5	3	4	$25
ADVERTISING	3	2	2	3	2	2	$13
	0	0	0	0	0	0	$0
TOTAL	$6,007	$4,414	$5,879	$6,552	$3,780	$5,412	$32,044
FIXED ASSETS							
EQUIP - PRIOR	8,606	6,325	8,423	9,388	5,416	7,754	45,912
EQUIP - CURR	3,962	2,912	3,878	4,322	2,494	3,570	21,138
EQUIP - FULLY DEP	1,052	773	1,030	1,148	662	948	5,614
BLDG - PRIOR	1,261	926	1,234	1,375	793	1,136	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
JUNE 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.67%	14.61%	18.36%	20.23%	12.04%	16.09%	100.00%
SALARIES-ADMIN	$2,626	$2,055	$2,583	$2,846	$1,694	$2,264	$14,066
SALARIES-CLERIC	1,347	1,054	1,325	1,460	869	1,161	7,216
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	9	7	8	9	6	7	46
WORK COMP INS	14	11	14	15	9	12	75
SUPPLIES	128	100	126	139	82	110	685
TELEPHONE	61	48	60	66	39	52	326
EMPL BENEFITS	434	339	427	470	280	374	2,324
PAYROLL TAXES	323	253	318	350	208	278	1,730
TRAVEL	185	145	182	201	120	160	993
IN SERVICE	13	10	12	14	8	11	68
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	20	16	20	22	13	17	108
OWNERS COMP	308	241	303	334	199	266	1,650
INS-PROP,LIAB,WC	22	17	22	24	14	19	120
DEPRECIATION	143	112	141	155	92	123	766
RENT	317	248	311	343	204	273	1,696
MAINTENANCE	26	20	25	28	17	22	137
FEES & PUBLIC	5	4	5	5	3	4	25
ADVERTISING	3	2	2	3	2	2	13
	0	0	0	0	0	0	0
TOTAL	$5,982	$4,680	$5,884	$6,482	$3,858	$5,157	$32,044
FIXED ASSETS							
EQUIP - PRIOR	8,571	6,706	8,431	9,288	5,528	7,388	45,912
EQUIP - CURR	3,946	3,088	3,882	4,276	2,545	3,402	21,138
EQUIP - FULLY DEP	1,048	820	1,031	1,136	676	903	5,614
BLDG - PRIOR	1,255	982	1,235	1,360	810	1,082	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

COST ALLOCATION
JULY 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.71%	14.72%	19.35%	20.17%	11.78%	15.26%	100.00%
SALARIES-ADMIN	$2,632	$2,071	$2,722	$2,838	$1,657	$2,146	$14,066
SALARIES-CLERIC	1,350	1,062	1,396	1,456	850	1,101	7,216
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	9	7	9	9	5	7	46
WORK COMP INS	14	11	15	15	9	11	75
SUPPLIES	128	101	133	138	81	104	685
TELEPHONE	61	48	63	66	38	50	326
EMPL BENEFITS	435	342	450	469	274	355	2,324
PAYROLL TAXES	324	255	335	349	204	264	1,730
TRAVEL	186	146	192	200	117	151	993
IN SERVICE	13	10	13	14	8	10	68
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	20	16	21	22	13	16	108
OWNERS COMP	309	243	319	333	194	252	1,650
INS-PROP,LIAB,WC	22	18	23	24	14	18	120
DEPRECIATION	143	113	148	155	90	117	766
RENT	317	250	328	342	200	259	1,696
MAINTENANCE	26	20	27	28	16	21	137
FEES & PUBLIC	5	4	5	5	3	4	25
ADVERTISING	3	2	3	3	2	2	13
	0	0	0	0	0	0	0
TOTAL	$5,996	$4,718	$6,201	$6,465	$3,776	$4,889	$32,044
FIXED ASSETS							
EQUIP - PRIOR	8,591	6,760	8,884	9,262	5,410	7,004	45,912
EQUIP - CURR	3,955	3,112	4,090	4,264	2,491	3,225	21,138
EQUIP - FULLY DEP	1,051	827	1,086	1,133	662	856	5,614
BLDG - PRIOR	1,258	990	1,301	1,357	792	1,026	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
AUGUST 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.10%	14.62%	18.85%	20.40%	12.20%	15.82%	100.00%
SALARIES-ADMIN	$1,915	$1,547	$1,994	$2,158	$1,291	$1,674	$10,578
SALARIES-CLERIC	1,010	816	1,052	1,138	681	883	5,581
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	9	7	9	10	6	8	50
WORK COMP INS	24	19	25	27	16	21	132
SUPPLIES	37	30	38	42	25	32	204
TELEPHONE	94	76	98	106	63	82	518
EMPL BENEFITS	505	408	526	569	341	442	2,791
PAYROLL TAXES	272	220	284	307	184	238	1,505
TRAVEL	214	173	223	241	144	187	1,183
IN SERVICE	4	3	4	5	3	4	22
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	(0)	(0)	(0)	(0)	(0)	(0)	(0)
OWNERS COMP	307	248	319	346	207	268	1,694
INS-PROP,LIAB,WC	29	23	30	32	19	25	158
DEPRECIATION	139	112	144	156	93	121	765
RENT	307	248	320	346	207	268	1,696
MAINTENANCE	46	38	48	52	31	41	257
FEES & PUBLIC	5	4	5	5	3	4	26
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$4,917	$3,972	$5,120	$5,540	$3,314	$4,298	$27,160
FIXED ASSETS							
EQUIP - PRIOR	8,311	6,715	8,655	9,364	5,602	7,265	45,912
EQUIP - CURR	3,826	3,091	3,985	4,311	2,579	3,345	21,138
EQUIP - FULLY DEP	1,016	821	1,058	1,145	685	888	5,614
BLDG - PRIOR	1,217	984	1,268	1,372	821	1,064	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
SEPTEMBER 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.02%	14.91%	18.11%	19.77%	13.38%	15.82%	100.00%
SALARIES-ADMIN	$1,906	$1,577	$1,915	$2,092	$1,415	$1,673	$10,578
SALARIES-CLERIC	1,005	832	1,011	1,104	747	883	5,581
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	9	7	9	10	7	8	50
WORK COMP INS	24	20	24	26	18	21	132
SUPPLIES	37	30	37	40	27	32	204
TELEPHONE	93	77	94	102	69	82	518
EMPL BENEFITS	503	416	505	552	373	441	2,791
PAYROLL TAXES	271	224	273	298	201	238	1,505
TRAVEL	213	176	214	234	158	187	1,183
IN SERVICE	4	3	4	4	3	4	22
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	(0)	(0)	(0)	(0)	(0)	(0)	(0)
OWNERS COMP	305	253	307	335	227	268	1,694
INS-PROP,LIAB,WC	28	24	29	31	21	25	158
DEPRECIATION	138	114	139	151	102	121	765
RENT	306	253	307	335	227	268	1,696
MAINTENANCE	46	38	46	51	34	41	257
FEES & PUBLIC	5	4	5	5	3	4	26
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$4,893	$4,049	$4,918	$5,371	$3,633	$4,296	$27,160
FIXED ASSETS							
EQUIP - PRIOR	8,272	6,845	8,314	9,078	6,141	7,262	45,912
EQUIP - CURR	3,808	3,152	3,828	4,180	2,828	3,343	21,138
EQUIP - FULLY DEP	1,011	837	1,017	1,110	751	888	5,614
BLDG - PRIOR	1,212	1,003	1,218	1,330	900	1,064	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
OCTOBER 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	18.14%	14.64%	18.12%	18.84%	14.24%	16.02%	100.00%
SALARIES-ADMIN	$1,919	$1,549	$1,916	$1,993	$1,507	$1,695	$10,578
SALARIES-CLERIC	1,012	817	1,011	1,052	795	894	5,581
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	9	7	9	9	7	8	50
WORK COMP INS	24	19	24	25	19	21	132
SUPPLIES	37	30	37	38	29	33	204
TELEPHONE	94	76	94	98	74	83	518
EMPL BENEFITS	506	409	506	526	398	447	2,791
PAYROLL TAXES	273	220	273	284	214	241	1,505
TRAVEL	215	173	214	223	169	190	1,183
IN SERVICE	4	3	4	4	3	4	22
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	(0)	(0)	(0)	(0)	(0)	(0)	(0)
OWNERS COMP	307	248	307	319	241	271	1,694
INS-PROP,LIAB,WC	29	23	29	30	23	25	158
DEPRECIATION	139	112	139	144	109	123	765
RENT	308	248	307	320	242	272	1,696
MAINTENANCE	47	38	46	48	37	41	257
FEES & PUBLIC	5	4	5	5	4	4	26
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$4,927	$3,976	$4,920	$5,117	$3,869	$4,351	$27,160
FIXED ASSETS							
EQUIP - PRIOR	8,328	6,721	8,317	8,651	6,540	7,355	45,912
EQUIP - CURR	3,834	3,094	3,829	3,983	3,011	3,386	21,138
EQUIP - FULLY DEP	1,018	822	1,017	1,058	800	899	5,614
BLDG - PRIOR	1,220	985	1,218	1,267	958	1,077	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0

NURSING HOME MANAGERS
COST ALLOCATION
NOVEMBER 2000

	D'ADR	HLTP	JVILLE	MEAD M	MENARD	SUNRISE	TOTAL
ALLOC PERCENT	19.02%	13.93%	18.20%	18.16%	14.04%	16.65%	100.00%
SALARIES-ADMIN	$2,012	$1,473	$1,925	$1,921	$1,486	$1,761	$10,578
SALARIES-CLERIC	1,062	777	1,016	1,013	784	929	5,581
SALARIES-ACTIV	0	0	0	0	0	0	0
SALARIES-NURSE	0	0	0	0	0	0	0
ACCOUNTING	10	7	9	9	7	8	50
WORK COMP INS	25	18	24	24	19	22	132
SUPPLIES	39	28	37	37	29	34	204
TELEPHONE	98	72	94	94	73	86	518
EMPL BENEFITS	531	389	508	507	392	465	2,791
PAYROLL TAXES	286	210	274	273	211	251	1,505
TRAVEL	225	165	215	215	166	197	1,183
IN SERVICE	4	3	4	4	3	4	22
MEDICAL CONSULT	0	0	0	0	0	0	0
MACHINE RENTAL	(0)	(0)	(0)	(0)	(0)	(0)	(0)
OWNERS COMP	322	236	308	308	238	282	1,694
INS-PROP,LIAB,WC	30	22	29	29	22	26	158
DEPRECIATION	146	107	139	139	107	127	765
RENT	323	236	309	308	238	282	1,696
MAINTENANCE	49	36	47	47	36	43	257
FEES & PUBLIC	5	4	5	5	4	4	26
ADVERTISING	0	0	0	0	0	0	0
	0	0	0	0	0	0	0
TOTAL	$5,167	$3,783	$4,943	$4,932	$3,814	$4,521	$27,160
FIXED ASSETS							
EQUIP - PRIOR	8,734	6,394	8,356	8,337	6,448	7,642	45,912
EQUIP - CURR	4,021	2,944	3,847	3,838	2,968	3,519	21,138
EQUIP - FULLY DEP	1,068	782	1,022	1,019	788	934	5,614
BLDG - PRIOR	1,279	937	1,224	1,221	944	1,119	6,725
BLDG - CURR	0	0	0	0	0	0	0
BLDG - FULLY DEP	0	0	0	0	0	0	0